

## OVERVIEW >>

As providers transition from fee-for-service to value-based models, they will be paid based on the health outcomes they achieve as opposed to the volume of care delivered. This significant change means providers will need to assess risk differently in order to remain competitive in a new environment.

So how can providers determine whether entering into value-based models are worth the risk? [A new publication from the Society of Actuaries](#) provides several key considerations for providers as they evaluate their patient care under alternative payment models (APMs):

## PATIENT ATTRIBUTION IS KEY >>

Patients often receive care from multiple providers. However, assessment of value-based care ultimately requires the identification of a single provider who is responsible for a patient's health outcomes and expenditures. That's where the idea of patient attribution comes in. Attribution is the process of assigning patients to the provider entity who will ultimately be responsible for the cost and quality of their care. The process uses data sources like medical claims to assign patients to the appropriate provider. Attribution affects a provider's risk pool, medical loss ratio, and overall financial picture.

## PATIENT ATTRIBUTION REQUIRES ADDITIONAL RISK MANAGEMENT FOR SUCCESSFUL IMPLEMENTATION >>

Providers groups in APMs only take on performance and insurance risk for the attributed patients within the plan. Therefore, patient attribution is crucial for providers to understand the additional risk management needed under value-based arrangements. An understanding of this risk can help providers define their patient/payer mix and the revenue needed to cover expenses for the attributed patients that they serve. Patient attribution is valuable for both episode-based payment models (delivering a suite of care to patients over a period of time, such as maternity care) and patient-based or population-based models (such as accountable care organizations).

## AN ATTRIBUTION METHODOLOGY SHOULD SUPPORT THE DISTRIBUTION OF GAINS AND LOSSES >>

An attribution methodology should support the distribution of the gains or losses to the provider entity, whether it's an episode-based or population-based payment model. This helps ensure the provider has adequate finances to measure their population's risk.

### THERE ARE THREE BASIC METHODS FOR ATTRIBUTION:

#### 1. Patient choice:

a process where patients indicate a provider they would like to be responsible for their care. This method is optimal if care patterns are frequent, but can be hard to enforce with low-cost members who may not choose a provider.

#### 2. Geographic:

uses zip codes for a high capture rate, but lacks the sensitivity for reflecting care utilization across the spectrum.

#### 3. Visit-based:

an algorithm-based approach that uses claims data. It is more universally trusted, but can be administratively complex and highly dependent on data available at the provider level.

The method by which shared savings or losses are assigned to providers will also establish the incentives for engaging providers to actively participate and perform under the terms of the risk contract. It's important to understand that the presence of these financial incentives may also increase engagement by providers, while the absence of any specific financial incentive may reduce engagement.

## WHEN IMPLEMENTING ATTRIBUTION, IT'S CRUCIAL FOR THE RATES TO BE ACTUARIALLY SOUND >>

When rates are actuarially sound, it means they've been evaluated and projected to provide all reasonable, appropriate and attainable costs that are required under the terms of contract for managing a patient population's health. The current practice when implementing attribution is to take a risk pool for which the rates are actuarially sound, and then split the group across various provider risk contracts. However, this may lead to rates and budgets that may not meet the definition of actuarial soundness for the specific organization.

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### THIS CAUSES TWO CONCERNS:

1. Rates may not promote the accountability of the program administration, therefore increasing medical expenditures by paying providers a disproportionately high reimbursement relative to the risk they are managing.
2. The solvency of the provider may be in question if the reimbursement is not sufficient to cover expenses incurred providing care for the risk they are managing.

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Establishing actuarially sound rates in organizations assuming risks ensures that the organizations are paying and providers are receiving fair, equitable, and adequate resources to manage their population's health.

## COMPLEX MEMBERS, PATIENT TURNOVER AND UNASSIGNABLE MEMBERS SHOULD BE FACTORED INTO ATTRIBUTION >>

Many contracts exclude medically complex members from attribution due to high cost conditions that make it difficult to assign care to one particular provider. Although the identification and exclusion of high-cost patients is intended to mitigate their impact on the variability of patient costs in a population, small variations in the prevalence of these patients can cause marked changes in total experience, especially if the population is small.

Another key consideration is the patient turnover rate, which can also vary widely. With 40-60 percent annual re-attribution, there can be significant variation in risk-adjusted cost trends between attributed and non-attributed members that form the basis of any cost forecasting and staffing models used by physician groups that are entering new at-risk contract models.

It's also important to note that not all members will be able to be attributed to a particular provider. This may be because they have not received services during the attribution period or because the services they received were not used in the attribution process (i.e. new enrollees to the health plan).

Often these unassignable members are very low-cost members who do not stay current on preventive measures. Attribution methods may deal with these members by alternate means, such as by auto-assigning them to providers, or excluding from the value-based contract.

## ATTRIBUTION WILL CONTINUE TO EVOLVE >>

This paper outlines key considerations based on current attribution processes. However, targeted ways for plans to attribute patients to their most appropriate provider groups for performance measurement and fiscal risk accountability will continue to evolve in the future.

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Please visit <https://www.soa.org/research-reports/2018/patient-attribution/> to review the full publication, "Patient Attribution: The Basis for all Value-Based Care."